New Choices Waiver

Medication Management Review

Name: _____ DOB: _____ Medicaid ID: _____

The medication management review should correspond with the MDS-HC assessment. Anytime a new MDS-HC assessment is required, a new Medication Management Review form should also be filled out. A quarterly medication management review should also take place, falling within the calendar month of the third month following the MDS-HC or previous quarterly medication management review (i.e. January, April, July, and October).

Corresponding MDS-HC Assessment Date: _____

Client's Current Medications

Name	Diagnosis	Dose	Route	# Taken	Frequency

Who is responsible for administering medications? ☐ Facility Staff ☐ Client ☐ Other_____

If the facility staff is responsible for administering medications, was the Medication Administration Record (MAR) for the past three calendar months reviewed? ☐ Yes ☐ No

Concerns related to Medication Administration or Compliance: ☐ N/A

Potential Medication Interactions Identified: ☐ N/A

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Does the client receive laboratory testing to monitor therapeutic levels of any medications listed? ☐ Yes ☐ No

If yes, please describe the services in place to provide this testing. Identify any issues or potential issues that have occurred over the past three calendar months**.**

Document follow- up that occurred (including outcomes) with the prescribing physician, the facility, or the client to address any concerns identified above.

RN Name: _____ Signature: _____ Date: _____

The quarterly review will identify any changes in the medication regime, concerns that are ongoing or not previously identified, and follow-up that occurred (including outcomes) with the prescribing physician, the facility, or the client to address the concerns identified.

Quarter 1 Review (3 months following MDS-HC)

RN Name: _____ Signature: _____ Date: _____

Quarter 2 Review (6 months following MDS-HC)

RN Name: _____ Signature: _____ Date: _____

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Quarter 3 Review (9 months following MDS-HC)

RN Name: _____ Signature: _____ Date: _____